907 KAR 1:038. Hearing Program coverage provisions and requirements.

RELATES TO: KRS 205.520, 334.010(4), (9), 334A.020(5), 334A.030, 42 C.F.R. 441.30, 447.53, 457.310, 42 U.S.C. 1396a, b, d, 1396r-6

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the Medicaid Program provisions and requirements regarding the coverage of audiology services and hearing instruments.

Section 1. Definitions. (1) "Audiologist" is defined by KRS 334A.020(5).

(2) "CPT code" means a code used for reporting procedures and services performed by medical practitioners and published annually by the American Medical Association in Current Procedural Terminology.

(3) "Department" means the Department for Medicaid Services or its designee.

(4) "Enrollee" means a recipient who is enrolled with a managed care organization.

(5) "Federal financial participation" is defined by 42 C.F.R. 400.203.

(6) "Healthcare Common Procedure Coding System" or "HCPCS" means a collection of codes acknowledged by the Centers for Medicare and Medicaid Services (CMS) that represents procedures or items.

(7) "Hearing instrument" is defined by KRS 334.010(4).

(8) "Managed care organization" means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined in 42 C.F.R. 438.2.

(9) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(10) "Recipient" is defined by KRS 205.8451(9).

(11) "Specialist in hearing instruments" is defined by KRS 334.010(9).

Section 2. General Requirements. (1)(a) For the department to reimburse for a service or item, the service or item shall:

1. Be provided:

a. To a recipient under the age of twenty-one (21) years, including the month in which the recipient becomes twenty-one (21); and

b. By a provider who is:

(i) Enrolled in the Medicaid Program pursuant to 907 KAR 1:672;

(ii) Except as provided by paragraph (b) of this subsection, currently participating in the Medicaid Program pursuant to 907 KAR 1:671; and

(iii) Authorized to provide the service in accordance with this administrative regulation;

2. Be covered in accordance with this administrative regulation;

3. Be medically necessary; and

4. Have a CPT code or HCPCS code that is listed on the Department for Medicaid Services Hearing Program Fee Schedule.

(b) In accordance with 907 KAR 17:015, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the fee-for-service Medicaid Program.

(2)(a) If a procedure is part of a comprehensive service, the department shall:

1. Not reimburse separately for the procedure; and

2. Reimburse one (1) payment representing reimbursement for the entire comprehensive ser-

vice.

(b) A provider shall not bill the department multiple procedures or procedural codes if one (1) CPT code or HCPCS code is available to appropriately identify the comprehensive service provided.

(3) A provider shall comply with:

(a) 907 KAR 1:671;

(b) 907 KAR 1:672; and

(c) All applicable state and federal laws.

(4)(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this subsection may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

(c) Nonduplication of payments and third-party liability shall be in accordance with 907 KAR 1:005.

(d) A provider shall comply with KRS 205.622.

(5)(a) An in-state audiologist shall:

1. Maintain a current, unrevoked, and unsuspended license in accordance with KRS Chapter 334A;

2. Before initially enrolling in the Kentucky Medicaid Program, submit proof of the license referenced in subparagraph 1 of this paragraph to the department; and

3. Annually submit proof of the license referenced in subparagraph 1 of this paragraph to the department.

(b) An out-of-state audiologist shall:

1. Maintain a current, unrevoked, and unsuspended license to practice audiology in the state in which the audiologist is licensed;

2. Before initially enrolling in the Kentucky Medicaid Program, submit proof of the license referenced in subparagraph 1 of this paragraph to the department;

3. Annually submit proof of the license referenced in subparagraph 1 of this paragraph to the department;

4. Maintain a Certificate of Clinical Competence issued to the audiologist by the American Speech-Language-Hearing Association; and

5. Before enrolling in the Kentucky Medicaid Program, submit proof of having a Certificate of Clinical Competence issued to the audiologist by the American Speech-Language-Hearing Association.

(c) If an audiologist fails to comply with paragraph (a) or (b) of this subsection, as applicable based on if the audiologist is in-state or out-of-state, the:

1. Audiologist shall be ineligible to be a Kentucky Medicaid Program provider; and

2. Department shall not reimburse for any service or item provided by the audiologist effective with the date the audiologist fails or failed to comply.

(6)(a) An in-state specialist in hearing instruments shall:

1. Maintain a current, unrevoked, and unsuspended license issued by the Kentucky Licensing Board for Specialists in Hearing Instruments;

2. Before initially enrolling in the Kentucky Medicaid Program, submit proof of the license referenced in subparagraph 1 of this paragraph to the department;

3. Annually submit proof of the license referenced in subparagraph 1 of this paragraph to the department;

4. Maintain a Certificate of Clinical Competence issued to the specialist in hearing instruments

by the American Speech-Language-Hearing Association; and

5. Before enrolling in the Kentucky Medicaid Program, submit proof of having a Certificate of Clinical Competence issued to the specialist in hearing instruments by the American Speech-Language-Hearing Association.

(b) An out-of-state specialist in hearing instruments shall:

1. Maintain a current, unrevoked, and unsuspended license issued by the licensing board with jurisdiction over specialists in hearing instruments in the state in which the license is held;

2. Before initially enrolling in the Kentucky Medicaid Program, submit proof of the license referenced in subparagraph 1 of this paragraph to the department;

3. Annually submit proof of the license referenced in subparagraph 1 of this paragraph to the department;

4. Maintain a Certificate of Clinical Competence issued to the specialist in hearing instruments by the American Speech-Language-Hearing Association; and

5. Before enrolling in the Kentucky Medicaid Program, submit proof of having a Certificate of Clinical Competence issued to the specialist in hearing instruments by the American Speech-Language-Hearing Association.

(c) If a specialist in hearing instruments fails to comply with paragraph (a) or (b) of this subsection, as applicable based on if the specialist in hearing instruments is in-state or out-of-state, the:

1. Specialist in hearing instruments shall be ineligible to be a Kentucky Medicaid Program provider; and

2. Department shall not reimburse for any service or item provided by the specialist in hearing instruments effective with the date the specialist in hearing instruments fails or failed to comply.

Section 3. Audiology Services. (1) Audiology service coverage shall be limited to one (1) complete hearing evaluation per calendar year.

(2) Unless a recipient's health care provider demonstrates, and the department agrees, that an additional hearing instrument evaluation is medically necessary, a hearing instrument evaluation shall:

(a) Include three (3) follow-up visits, which shall be:

1. Within the six (6) month period immediately following the fitting of a hearing instrument; and

2. Related to the proper fit and adjustment of the hearing instrument; and

(b) Include one (1) additional follow-up visit, which shall be:

1. At least six (6) months following the fitting of the hearing instrument; and

2. Related to the proper fit and adjustment of the hearing instrument.

(3)(a) A referral by a physician to an audiologist shall be required for an audiology service.

(b) The department shall not cover an audiology service if a referral from a physician to the audiologist was not made.

Section 4. Hearing Instrument Coverage. Hearing instrument benefit coverage shall:

(1) If the benefit is a hearing instrument model, be for a hearing instrument model that is:

(a) Recommended by an audiologist licensed pursuant to KRS 334A.030; and

(b) Available through a Medicaid-participating specialist in hearing instruments; and

(2) Except as provided by Section 5(3) of this administrative regulation, not exceed $800 per ear every thirty-six (36) months.

Section 5. Replacement of a Hearing Instrument. (1) The department shall reimburse for the replacement of a hearing instrument if:

(a) A loss of the hearing instrument necessitates replacement;

(b) Extensive damage has occurred necessitating replacement; or

(c) A medical condition necessitates the replacement of the previously prescribed hearing instrument in order to accommodate a change in hearing loss.

(2) If replacement of a hearing instrument is necessary within twelve (12) months of the original fitting, the replacement hearing instrument shall be fitted upon the signed and dated recommendation from an audiologist.

(3) If replacement of a hearing instrument becomes necessary beyond twelve (12) months from the original fitting:

(a) The recipient shall be examined by a physician with a referral to an audiologist; and

(b) The recipient's hearing loss shall be re-evaluated by an audiologist.

Section 6. Noncovered services. The department shall not reimburse for:

(1) A routine screening of an individual or group of individuals for identification of a hearing problem;

(2) Hearing therapy except as covered through the six (6) month adjustment counseling following the fitting of a hearing instrument;

(3) Lip reading instructions except as covered through the six (6) month adjustment counseling following the fitting of a hearing instrument;

(4) A service for which the recipient has no obligation to pay and for which no other person has a legal obligation to provide or to make payment;

(5) A telephone call;

(6) A service associated with investigational research; or

(7) A replacement of a hearing instrument for the purpose of incorporating a recent improvement or innovation unless the replacement results in appreciable improvement in the recipient's hearing ability as determined by an audiologist.

Section 7. Equipment. (1) Equipment used in the performance of a test shall meet the current standards and specifications established by the American National Standards Institute.

(2)(a) A provider shall ensure that any audiometer used by the provider or provider's staff shall:

1. Be checked at least once per year to ensure proper functioning; and

2. Function properly.

(b) A provider shall:

1. Maintain proof of calibration and any repair, if any repair occurs; and

2. Make the proof of calibration and repair, if any repair occurs, available for departmental review upon the department's request.

Section 8. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 9. Appeal Rights. An appeal of a negative action regarding a Medicaid recipient who is:

(1) Enrolled with a managed care organization shall be in accordance with 907 KAR 17:010; or

(2) Not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

Section 10. Incorporation by Reference. (1) The "Department for Medicaid Services Hearing Program Fee Schedule", December 2013, is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, Cabinet for Health and Family Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m. or online at the de-

partment's Web site at http://www.chfs.ky.gov/dms/incorporated.htm. (2 Ky.R. 110; eff. 9-10-1975; 6 Ky.R. 646; 7 Ky.R. 403; eff. 10-1-1980; 860; eff. 6-3-1981; 12 Ky.R. 1786; 13 Ky.R. 16; eff. 6-10-1986; Recodified from 904 KAR 1:038, 6-10-1986; 18 Ky.R. 1625; eff. 1-10-1992; 20 Ky.R. 1714; eff. 2-2-1994; 23 Ky.R. 4009; 24 Ky.R. 119; eff. 6-18-1997; 25 Ky.R. 1254; 1660; eff. 1-19-1999; 28 Ky.R. 944; 1404; eff. 12-19-2001; 33 Ky.R. 594; 1377; 1560; eff. 1-5-2007; 34 Ky.R. 1820; 2110; eff. 4-4-2008; TAm 7-16-2013; 40 Ky.R. 1945; 2481; 2712; eff. 7-7-2014.)